Report to Legislature on the Status of Applications for Enhanced Federal Funding

Line Item 4000-0328 of the FY2017 budget appropriated $50,000 for the Executive Office of Health and Human Services (EOHHS) to pursue, enhance and submit applications for existing or new state plan amendments, state plan options, state waiver or demonstration requests, and federal grants for federal approval under the Patient Protection and Affordable Care Act, 42 U.S.C. 18001 et seq. In this report, EOHHS provides an update to the House and Senate Committees on Ways and Means on the status of submitted and pending applications for the projects identified in the line item and the projected fiscal impact of federal approval for these applications.

(a) the development and implementation of a modern, digital integrated eligibility system as required by the last paragraph of section 16 of chapter 6A of the General Laws in order to achieve maximum federal reimbursement;

As was stated in a letter to the Senate and House Clerks on October 2, 2015, The Commonwealth is committed to developing an IES that will improve the process of applying for benefits while also improving administrative accuracy and eliminating avoidable redundancies. EOHHS is working to implement IES together with an integrated service delivery model (also known as "no wrong door"). While many improvements have already been made, it is important for Massachusetts to continue to make many more process and system enhancements. When fully implemented, IES will support a better consumer experience, more integrated and coordinated care delivery, and more efficient program administration.

Over the last four years, work has progressed on the development of the IES, but due to various unforeseen events the system implementation has been delayed. In October of 2011, Massachusetts submitted an Initial Advanced Planning Document to the Centers for Medicare and Medicaid Services (CMS) for the adoption of a Health Insurance Exchange Integrated Eligibility System (HIX-IES) supporting the Commonwealth's multiple agencies. This HIX-IES was to be scaled out from the Health Insurance Exchange (HIX) portal and rules engine being developed for the Commonwealth by CGI.

As you know, in early 2014 the CGI HIX solution was determined to be a failure. The Commonwealth terminated the CGI contract and began implementing the hCentive Insurance Marketplace solution with Medicaid customizations via contracting with Optum Health Care Technologies. The hCentive application is a Commercial Off The Shelf (COTS) solution that was initially created for the commercial marketplace to meet the requirements of the federal Affordable Care Act (ACA). MassHealth has partnered with Optum/hCentive to enhance and develop Medicaid functionality within their software solution. The hCentive solution does not currently include an integrated IES solution.

The current focus of the HIX-IES project is on the continued success of the hCentive originally launched on November 11, 2014. As the system is stabilized, the Connector Authority and MassHealth are beginning to expand the hCentive functionality beyond the functionality included in the 2014 Go-Live release, in order to implement the full spectrum of services the new system can offer to Commonwealth residents.

In the interim, EOHHS is concentrating its efforts on enhancing and streamlining the application processes and expanding data sharing to improve coordination and eliminate redundancies between various state agencies. Here are a few examples of how EOHHS has streamlined the application process for state benefit programs:

- Consumers who are deemed eligible for cash assistance through the Department of Transitional Assistance (DTA) are now enrolled in MassHealth.
- Children who are in the care and custody of the Department of Children and Families (DCF) are now immediately enrolled in MassHealth coverage through the electronic transfer of information from DCF to MassHealth.

Additional examples of how EOHHS has worked to improve data sharing between state agencies:

- DTA now provides the Department of Housing and Community Development (DHCD) with the necessary information to confirm financial eligibility for otherwise qualified consumers who apply for Low Income Home Energy Assistance Program (LIHEAP).
- DTA and MassHealth share data with the Department of Elementary and Secondary Education (DESE) to identify children who are then eligible for free school meals.
- Through an expedited eligibility renewal process, certain individuals who are receiving Medicaid and Supplemental Nutrition Assistance Program (SNAP) benefits now have their MassHealth benefits renewed using DTA's SNAP data at the time of their annual review.

EOHHS currently has various projects underway to help assess business processes that allow multiple agencies to access and share data. These initiatives are the building blocks to the ultimate goal of an integrated eligibility system.

(b) the receipt of federal reimbursement for services provided to an eligible Medicaid beneficiary that are available without charge to the beneficiary, including services that are available without charge to the community at large, known as "free care";

A State Plan Amendment (SPA) was submitted on 9/29/2016 which would allow additional reimbursement for all medically necessary MassHealth covered services provided to MassHealth members by participating School Districts and Local Educational Authorities (LEAs), including all services provided free of charge to the public. When fully implemented, the proposed amendment is estimated to result in annual aggregate claimable expenditures of $80,000,000 for SFY 2018, representing approximately $40,000,000 in additional federal funds and $40,000,000 in LEAs funds in lieu of the state's share.

(c) the 1915(i) home and community-based services state plan authorized under 42 U.S.C. 1396n(i);

Under the previous administration, a 1915(i) SPA application was submitted in December 2014 with the intent of enabling federal claiming for state home care program expenditures for MassHealth eligible individuals. In its review, CMS raised concerns about fundamental aspects of the current home care program structure. This is a complex undertaking that would require extensive negotiations with CMS and/or consideration of making changes to important aspects of existing programs prior to any resubmission.

EOHHS has engaged a consultant to conduct a full evaluation of all existing waivers and to provide input on opportunities including use of section 1915(i) of the State plan. MassHealth will consider how this optional addition to the State plan may or may not fit within the foundational fabric of MassHealth payment reform, program integrity, and other anticipated changes.

(d) the authorization of coverage for postpartum placement of long acting reversible contraception;

MassHealth is currently reviewing its long acting reversible contraception (LARC) coverage policy to assess whether it is necessary and appropriate to submit a SPA. To date, MassHealth has convened focus groups with providers and hospital administrators; performed an analysis of state policy, with outreach to specific states as well as continued participation in the LARC working group of the Association of State and Territorial Health Organizations (ASTHO), a collaborative specifically looking at LARC immediate postpartum insertion; and conducted a literature review of the evidence for postpartum LARC insertion. A fiscal impact has not yet been determined but will be calculated based on any policy decisions.

(e) the pursuit of expanded federal reimbursement for lead poisoning testing and follow-up services;

Lead testing and follow-up work by the Department of Public Health (DPH) has traditionally been supported (in part or fully) by federal dollars via the Maternal Childhood Health Block Grant, or lead funds from the federal Center for Disease Control. DPH plans to begin exploring the "pursuit of expanded federal reimbursement for lead poisoning testing and follow-up services" in earnest in October 2016 and will make every effort to leverage these expansion funds are carved out from the traditional funding stream to avoid double dipping.

(f) the pursuit of Medicaid coverage for justice-involved individuals including, but not limited to, individuals on parole, probation, home confinement or pre-trial supervision or residing in a halfway house and deemed eligible under federal definition;

MassHealth worked collaboratively with the County Sheriff Departments and the Department of Correction to implement a process effective July 1, 2015 that addresses two key components for justice involved individuals:

- Providing Medicaid coverage for individuals within the correctional system who receive services in a hospital inpatient setting during their incarceration period; and
- Enhancing the pre-release process for the approval/reactivation of MassHealth medical benefits for those who qualify and are scheduled to be reintegrated into the community.

In partnership, a streamlined application process has been developed specifically for use by correctional facilities to ensure expeditious access to MassHealth benefits for both inpatient services and upon release. Future online eligibility systems enhancements are being developed that will enable additional automation of the process.

The estimated net fiscal impact of this project is a $10M - $15M increase in Federal Financial Participation (FFP) for SFY16.

(g) the Medicaid electronic health record incentive program;

The Medicaid electronic health record incentive program currently has an approved grant application for Federal Fiscal Year 2017. A grant application for Federal Fiscal Year 2018 is still under development and the fiscal impact is still being assessed.

(h) the 1915(k) community first choice state plan option authorized under 42 U.S.C. 1396n(k);

Section 1915(k) of the Social Security Act was authorized by the Affordable Care Act. An approved 1915(k) SPA would create a new entitlement to certain community-based services, including attendant services and skills training, back-up systems, support systems, and training for members at facility level of care and eligible under the State plan up to 150% of the Federal Poverty Level (FPL). The 1915(k) SPAs may also be used to authorize expanded assistive technology services, and the costs of transitions for members moving from a long-term care facility to the community.

In December 2015, the federal Centers for Medicare and Medicaid Services (CMS) released a report on community first choice implementation in the four states that had a 1915(k) SPA in place at that time. The states that have pursued it did so in part as a way to expand access to waiver-like home and community based services. Early experience from some of the states with 1915(k) SPAs found that the 6% FMAP increase was insufficient to cover the cost of increased support hours for enrollees, or the cost of CFC enrollment increases. *(https://www.medicaid.gov/medicaid/hcbs/downloads/cfc-final-report-to-congress.pdf).* Many states have not pursued this SPA due to the administrative burden and additional State costs.

In exchange for the creation of new member benefits, the Commonwealth would qualify for a 6% increase in the Federal Medical Assistance Percentage (FMAP) for services claimed under this SPA. The enhanced FMAP could not be claimed on related administrative costs, or on similar services authorized under other sections of the State Plan or other waivers. A 1915(k) SPA would result in additional costs to the Commonwealth, which would exceed the 6% increase in FMAP, due to the following required increase in, or creation of benefits:

- Expanded eligible population (individuals requiring cueing and supervision assistance beyond HCBS waiver eligible/enrolled population)
- Expand services for currently eligible population:
    - Cueing and supervision personal care
    - Back-up plan
- Administering face-to-face functional assessment
- Determination of facility Level of Care (clinical eligibility) annually
- Person-centered plan of services and supports
- Facilitation and support for Development and Implementation Council
- Infrastructure to qualify and support cueing and supervision assistance providers; to procure and oversee agency-provider model (optional); and to support self-directed budgeting (optional)
- Data collection mechanism for collecting type of disability, education level, and employment status

- Data reporting, supported by moderate analysis
- Establish, maintain and reporting from a comprehensive continuous quality assurance system. This would require additional staff, as well as IT systems and business processes to support collection, maintenance, analysis, and reporting of quality information.

MassHealth has already made cueing and supervision personal care available in certain discrete programs, which allows the benefit to be provided in the context of a broader package of supports to meet the needs of individuals (e.g., ABI, TBI and Frail Elder Waivers, One Care; and can be provided in SCO as a substitution service). Through the newly negotiated 1115 Demonstration Waiver, MassHealth will have authority beginning in SFY18 to pay for certain transition costs for members in accountable and managed care delivery systems. These approaches have allowed MassHealth to test the provision of broader benefits through programs with the ability to cap enrollment (and cost liabilities), and in delivery systems with high value, rather than broadly creating an entitlement for most MassHealth members.

As noted earlier, MassHealth is now in the process of engaging a consultant to do a full evaluation of all existing waivers and to provide input on revenue-enhancement opportunities, including the use of section 1915(k) of the State plan. MassHealth will consider how this optional addition to the State Plan fits within the foundational fabric of MassHealth payment reform, program integrity, and other anticipated changes.

(i) the pursuit of expanded federal reimbursement for comprehensive family planning services;

MassHealth does not plan to pursue a SPA to expand family planning services at this time. MassHealth already provides family planning services for adult non-disabled members up to 133% FPL, children up to 150% FPL and pregnant women up to 200% FPL. Following the eligibility expansions in the Affordable Care Act, MassHealth and Connector Care programs now cover family planning services for many newly eligible members who previously may have accessed family planning services through DPH funded programs.

MassHealth estimates implementation of the SPA would result in a net cost of $7.5M gross/ $1.2M net to the State, which includes anticipated enhanced revenue and assumes that FFP from the DPH's Sexual and Reproductive Health Program (SRHP) is also reallocated to MassHealth. Furthermore, due to necessary IT systems changes, this could not be implemented until late 2017 at the earliest.